In the Forefront

The Physician Profile System

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■ *The Physician Profile System is currently the most efficient and equitable mechanism of administering the payment to physicians under the usual and customary charge programs. Local peer review must be closely linked with the system to provide the assurance of reasonableness of charges, to resolve differences of opinion, and to scrutinize the utilization of health care resources.*

In actual practice, the Profile System permits for gradually increasing charges, both for the individual physician and for the medical community. It is equally capable of giving effect to lowered charges which sometimes follow technologic improvements.

Usual and customary programs have not proved to be inflationary, and have developed conservative trend patterns which permit realistic prediction of future program costs. Experience has shown that physicians have not abused the usual and customary charge programs. Administrative and peer review devices provide an impressive array of checks and safeguards against abuses in the utilization of benefits and in the payment of physicians' charges.

THE PAYMENT OF sums of money by insurance carriers and prepayment plans to physicians for the services they provide to subscribers or beneficiaries is a rapidly growing activity. The enactment of Public Law 89-97—Medicare—in 1965 produced a sudden massive increase in the volume of carrier payments to physicians and stimulated a broadened interest in the "how and how much" of this process.

A crucial question is: How much is a physician to be paid for a given service? Courts of law have traditionally held that a physician—like any other professional person — is entitled to be paid a *reasonable* charge for his services. One definition of "reasonable" would hold that a charge should be based upon "common usage and acceptance." Expanding upon this concept, Dr. Herman Stone and the Riverside County Medical Society in about 1960 proposed that the terms "usual," "customary" and "reasonable" be used to determine the appropriate or just fee to be paid a physician. These terms were rapidly accepted by the California Medical Association and the American Medical Association. With minor variations, they form the basis for determining "reasonable charges" under the Medicare law.

California Blue Shield is currently paying "reasonable charges" to physicians for services to more than 2.5 million Californians. Other Blue Shield plans and some commercial carriers throughout the nation are paying reasonable charges, "prevailing charges," or are administering "paid in full pro-

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grams" and "no-fee-schedule programs" which embody similar concepts.

Under reasonable charge programs, as administered by California Blue Shield, a physician's charge is paid if it is his *usual* charge for the service and if it is within the *customary range* of charges made by physicians in the same community for the same service, *or* if it is judged to be *reasonable* by *local peer review,* considering all of the medical facts and circumstances.

In order to process tens of thousands of claims daily—and to apply to each of them the test of usual and customary, or reasonable—a rapid, reliable system is essential.

The Physician Profile System is the most modern, most complete and most sophisticated administrative mechanism yet achieved for paying physicians on the basis of usual and customary or reasonable charges. When combined with local peer review on the question of "reasonableness," it would appear to be the most flexible, responsive and just system which could be devised at the present time for the payment of physicians in massive insurance and social programs.

Determination of The "Usual" Charge

Every charge which a physician makes for each service—as indicated by submitted claims—is recorded to his account and stored on the carrier's computer tapes. Over a period of time, it usually becomes apparent that the physician charges one fee for a specific service (RVS code number) more often than he charges any other fee for that service. The fee he charges most frequently is his *usual* fee for that specific service or procedure. For example: Dr. A. did 20 appendectomies in the last six months. He charged $200 for four of these, $250 in 12 cases, and $275 in the remaining four. From this, $250 is his usual fee for an appendectomy, and that is the "usual" that will be used to determine the fee he will be paid until a change occurs in his pattern of charges. If he starts to charge $275 more often than any other charge for appendectomy, $275 will show up within a short time as his most frequent and therefore his *usual* charge for an appendectomy.

A continuous record is kept of all of the charges made by each physician for the services he performs most frequently. The individual physician's *usual* charge for each of the services which make up his "profile" are updated monthly in order to reflect changes which may be taking place in his pattern of charges. (In some Blue Shield Plans physicians are asked to file their usual charges in advance and are permitted to change them at specified intervals, usually once or twice a year.)

Determination of The "Customary Range"

In actual practice in a medical community, the charges made by physicians for a given service tend to cluster about a certain figure which might be statistically identified as the "mode" or the "mean" (average) or the "median" (mid-point). A certain amount of variation above and below the "cluster point" is generally considered to be "normal." This variation reflects differences which might exist in the age, training and experience of the practitioners as well as in overhead and other items concerned with the economics of their practices. On the other hand, charges which exceed by a wide margin those which are commonly made, are considered to be outside the "customary range" and are reduced by the carrier to the "top of the customary range."

The determination of this "top of the range" is the most difficult and most controversial aspect of the system. The statistical methods and terms used to define the "top of the range" as well as their implications are often poorly understood, even among physicians and legislators. The term "percentile" is most often used in this regard and is defined: "That point or value in a serially ordered array of data below which occurs the corresponding percentage of cases."

Thus in the case of the appendectomy, if all the charges made for this operation by all the physicians in the community were laid out in order from the lowest to the highest, the 70th percentile (for example) would be the point—or level of charge below which 70 percent of the charges fall (Table 1).

In the usual and customary programs of California Blue Shield the 90th percentile of charges is used to determine the top of the customary range. Charges which exceed that point are reduced to the 90th percentile, even though they may be the usual charges of the physicians submitting the claims.

This does not mean that the top 10 percent of charges are reduced. As may be seen in the example in Table 1, the 90th percentile is the same as the 93.5th percentile, so that only the highest

6.5 percent of charges (those above the 93.5 percentile) are reduced. In many instances the 90th percentile may coincide with the 95th or even the 100th percentile. In actual application, use of the 90th percentile as the top of the range of customary charges results in reduction of fewer than 5 percent of all charges, and, for any one service, usually results in a reduction for only 2 or 3 percent of physicians.

As in the case of the *usual* charge, the *customary* ranges are constantly updated. Over 2,000 types of services performed by 24,000 physicians in 68 geographic areas of the state are under continual study. Some changes in the customary range criteria occur daily. This provides built-in assurance that the customary range will reflect changes in the charge patterns of the community.

Or Reasonable

When the computer prints out a check for payment of an amount below that which was billed by the physician, it signifies that the charge was above the physician's *usual* charge or above the *customary* range. It does not necessarily indicate that the charge was not reasonable. A patient may present a difficult, complex or unusual problem, requiring more than the usual amount of time, effort or exertion by the physician, thus justifying a charge over and above what might otherwise be paid. The decision as to the reasonableness of a charge in such circumstances is necessarily made by physicians and is a proper subject for local peer review.

Each county and district medical society has a functioning committee of physicians appointed for this purpose. Any physician who believes that his charges have been unfairly reduced, or that circumstances justify an increased fee in certain cases, should avail himself of the advice and assistance of his local peer review committee. The same mechanism is available to carriers and others who feel that physicians are unjustly raising their charges. The carrier usually follows the decision of the local review committee.

In some instances, not all parties may agree with the decisions of the local review committee. In California, an appeals mechanism has been established at the state level by the California Medical Association. Rules of procedure to assure "due process" have been developed by legal counsel for the guidance of local and state review committees. Final recourse may be had to the courts of law.

Questions and Problems

As the Physician Profile System has been implemented in different areas of the country, sometimes the first reactions have been antagonistic, expressions revealing apparent confusion at the seeming complexity of the system. But on further experience these reactions usually give way to surprise that it is really very simple.

Once the actual workings of the system are understood, there remain a number of important questions relating to the influence of the Physician Profile System on the level of fees and the costs of medical care. Some of these questions and their answers are contained in a recent Special Supplement of *The Blue Shield.* The following two questions and answers are direct quotes:

"Don't usual and customary programs tend to inflate physicians' charges?

"There is no evidence that these programs are inflationary over the long term. There has been some evidence that charges have increased in the early stages of some of the programs. This is largely attributable to their having caused some physicians to examine their fees for the first time in years."

"Won't usual and customary coverage lead to fee schedules?

"No. It is specifically designed not to influence fees. The question does raise two possibilities. The first is that the Plan may fail to keep charge levels current. Physicians have adequate defenses against this through agreements between the Plan and the Medical Society or through participating in both.

"The second possibility is that a significant percentage of physicians will respond to usual and customary coverage by seeking the maximum possible payments. If this happened it would destroy the checks and balances inherent in normal fee ranges. In theory this is possible. Physicians can destroy any prepayment mechanism. In practice, Blue Shield's experience is that if physicians are permitted to set fair fees, they will preserve the integrity of the process."

Administrators and others concerned with the financing of such programs as Workmen's Compensation insurance, which have traditionally used fixed fee schedules, have expressed the additional concern that usual and customary fees do not permit accurate prediction of program costs. This concern is unwarranted, as is shown by experience gained in usual and customary fee programs in

California, indicating a very consistent and predictable gradual increase in physicians' charges of approximately 4 percent per year. This rate of increase tends to confirm the findings of the *Physician Fee Index* published by the Bureau of Research and Planning of the California Medical Association since 1963. This study reports an annual rate of increase of 4.3 percent over a five-year period. The existence of such reliable trend figures makes realistic actuarial projections of program costs quite feasible.

Not Used for Medi-Cal

Although California's Medi-Cal law, implementing Title XIX of the Social Security Act, requires the payment of "reasonable charges" based upon "customary and prevailing" charges, the Physician Profile System cannot now be used in administering this program. In September 1967, the State Health and Welfare Agency imposed a regulation prohibiting the payment to physicians of fees in excess of the 60th percentile of charges being made on 1 January 1967.

The effect of this regulation, still operative, is to require reduction of the charges for the majority of services performed by the majority of physicians serving the program. A Profile System operating under such a restrictive fee ceiling would be entirely meaningless—like a baseball game played on a handball court. The Physician Profile System is largely self-regulating. The imposition of rigid external fiscal controls entirely negates its values and effectiveness.

Fiscal Stability and Consumer Protection

Among the many misconceptions about usual and customary charge programs is the erroneous belief that no restraint is exercised and no ceiling is placed upon the fees a physician may be paid. Nothing is further from the truth. There is a series of checks and restraints upon unusually high fees and unreasonable inflation and also upon the inappropriate and wasteful utilization of services.

In addition to the limiting factors inherent in the usual charge and in the top of the customary range, there are other factors and procedures which serve as protection against abuses.

Usual fees and customary ranges *may go down as well as up.* Technical advances from time to time make it easier to perform certain procedures, and charges then may be reduced. A recent example resulted from the effect of automated laboratory procedures on the charges for certain blood chemistry determinations. The Profile System promptly reflects such lowering of charges.

Local peer review involves much more than passing upon the reasonableness of a disputed fee. In many local medical societies panels of physicians personally inspect, on a rotating basis, up to 20 percent of all the claims submitted by local physicians, and must approve not only the fees charged but also the propriety of the services rendered. Physicians found habitually to "overcharge," or to "overprescribe" or in other ways to practice medicine which is not up to accepted community standards are subject to disciplinary procedures ranging from reprimand or recommendation of fee reduction to recommendations for legal action in cases of suspected fraud, or even to revocation of license. Utilization and fee review are conducted by consultants and advisors in the offices of carriers as well as at the local level.

A final check on unreasonable fees and inappropriate utilization lies within the legal responsibility of the carrier. As a contractor in governmental programs, the carrier has the legal obligation to pay only "reasonable" charges for "covered" services. In standard, non-governmental programs, the carrier has a moral as well as a legal obligation to protect and conserve the subscriber's premium dollars. Carriers that permit payments to escalate unreasonably or that are lax in their scrutiny of utilization are risking loss of subscribers and cancellation of governmental contracts.

TABLE 1.—*Determination of Percentile*

In a given county, during January 1969, 400 appendectomies were performed. The charges made by the operating physicians ranged from $180 to $350. The charges were distributed as follows:

Charge Per Case	*Number of Cases*	*% of Total No. of Cases*	*Cumulative % of Total No. of Cases (Percentile)*
$180	1	0.25	0.25
$200	100	25.00	25.25
$225	99	24.75	50.00
$240	125	31.25	81.25
$280	49	12.25	93.50
$300	24	6.00	99.50
$325	1	0.25	99.75
$350	1	0.25	100.00

In the above example, the 50th percentile of charges would be at $225. The 60th, 70th and 80th percentiles would all be $240, the 90th percentile would be at $280.